

Program Name	SID	FY 2026 Appropriated
Needle & Syringe Exchange Program	12100	\$ 513,515
Children's Health Initiative: Regular	12126	\$ 3,389,838

Aids Services	12236	\$ 5,366,231
Breast and Cervical Cancer Detection	12255	\$ 2,563,100
Immunization Services	12563	\$ 49,176,811

Lung Cancer Detection and Referrals	12672	\$ 479,137
Gun Violence Prevention	12645	\$ 4,404,299
Pancreatic Cancer Screening	12703	\$ 106,996
Public Health Response	12704	\$ 868,858

Community Health Services	16060	\$ 2,398,494
Rape Crisis	16103	\$ 616,233
X-Ray Screening and TB Care	16112	\$ 971,849

Local and District Depts. of Health	17009	\$ 6,509,802
Venereal Disease Control	17013	\$ 203,256
School Based Health Clinics	17019	\$ 13,540,721
<b>OCE Grand Total</b>		<b>\$ 91,109,140</b>

<b>What is the intent of the program??</b>	<b>Who does the program service</b>
<p>The purpose of the program is to prevent disease and enhance health outcomes for people who inject drugs, particularly in communities affected by human immunodeficiency virus (HIV) and hepatitis C (HCV), by reducing transmission of blood-borne infections and connecting participants to additional health and social services.</p>	<p>The program serves people who inject drugs. The primary focus is on populations at risk for HIV/HCV and other injection-related harms. The program also benefits communities impacted by injection drug use by reducing disease transmission and promoting safe disposal of used syringes. Additional services are provided to persons at risk of overdose or seeking linkage to care for HIV, STD, hepatitis screening, and substance use treatment services.</p>
<p>These funds support a broad range of programs designed to improve children's health, including Reproductive and perinatal Case Management, the operation of regional childhood lead treatment centers, Child sexual abuse clinics, medical homes for Children and Youth with Special Health Care Needs (CYSHCN), Newborn Genetic Disease/Metabolic Disorder Treatment Centers, and Community Outreach on Sickle Cell Disease.</p>	<p>CYSHCN Program provides community-based, culturally competent care coordination and family support services to over 9,200 CYSHCN. Asthma, ADHD, and Autism are the top three diagnosis of children and youth served in the program.</p> <p>Reproductive and Perinatal case management (RPCM) and Reproductive Health contracts provide comprehensive reproductive health services, screenings, referrals, education and case management to clients aged ten to twenty-two (10-22) per year. These include both preventative education, services and counseling to non-pregnant pre-teens and teens and interventional services for actual pregnant pre-teens, teens and young adults. These services include family planning services, perinatal, birthing and postpartum services aimed at reducing unintended teen pregnancies, and poor maternal outcomes, mortality and morbidity for pregnant and birthing young women.</p> <p>Child Sexual Abuse contracts provide comprehensive evaluation, interviews and appropriate referrals for children and youth, infant through age 17, suspected of being victims of sexual abuse and their families.</p>

<p>The purpose of Connecticut’s HIV/AIDS Services is to support prevention and care services in the community, such as educational materials, condom distribution, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), medical care, and support services for people living with HIV to improve health outcomes and reduce HIV transmission statewide.</p>	<p>This program serves People living with HIV/AIDS (PLWHA), Populations at increased risk for HIV, STD, hepatitis C, and Overdose. The program also serves Family and Supporters who may need access to resources to support PLWH.</p>
<p>These funds support breast and cervical screening, diagnostic testing, care navigation, and referral to treatment services for approximately 5,000 low income, uninsured, and underinsured CT residents each year. The program contracts with five health systems for screening, diagnostic and navigation services, as well as the CT Department of Correction for screenings for justice involved individuals.</p>	<p>Women in CT 40-64 years of age for mammograms and 21 to 64 years of age for clinical breast exams and pap tests, at or below 250% of the federal poverty level, have no health insurance, health insurance that does not cover these services, or who have a high insurance deductible.</p>
<p>Funding under this account is used to purchase, store, and distribute vaccines for routine immunizations included in the schedule for active immunizations required by Sec. 19a-7f. Vaccines supported by Connecticut Vaccine Program (CVP), includes COVID-19, diphtheria, Haemophilus influenzae type b (Hib), hepatitis A, hepatitis B, human papillomavirus (HPV), influenza, measles, mumps, rubella, rotavirus, RSV monoclonal antibody, polio, meningococcal, pertussis, pneumococcal, tetanus, and varicella (chickenpox). This account also pays for TB and STD medications distributed through an MOA with UConn Specialty Pharmacy to under and insured persons with TB and at risk populations with STDs.</p>	<p>The CVP serves all children in Connecticut and operates as a universal vaccine program. This fund supplements the federal Vaccines for Children program funding by specifically covering privately insured children who are not eligible for VFC. By filling this gap, the fund ensures that all children regardless of insurance status have access to recommended vaccines. This approach supports equitable access to immunizations statewide, helps maintain high vaccination coverage rates, and protects overall public health.</p>

<p>A Lung cancer early detection program has been established to fund and support healthcare organizations to (1) identify, recruit, and navigate eligible patients into lung cancer screening services, and if indicated, follow up treatment and services, (2) increase lung cancer screening by 15% at each organization, (3) educate CT general population concerning the benefits of lung cancer screening, (4) strengthen partnerships among the community, state, and federal agencies involved in lung cancer outreach, and (5) collect timely data lung cancer screening.</p>	<p>CT residents 50 to 80 years of age with who are uninsured or under-insured</p>
<p>OFIP's intent is to reduce firearm-related injury and death, determine community-level needs, fund and support effective community violence intervention programs, strengthen partnerships and collaboration, collect timely data on firearm-involved injury and death, evaluate effectiveness of programs, advocate for effective policies, and secure state and federal funding.</p>	<p>OFIP supports the growth and expansion of community-based programs in high-risk geographic areas through out the state. OFIP also expands public health initiatives statewide, such as promotion of safe storage through firearm safes.</p>
<p>The goal of this program is to inform people of the risks of pancreatic cancer and to make sure those at the greatest risk are getting the appropriate screenings. DPH will run an education campaign and operate a website with referral information. This program will also be included in a larger communications effort around cancer and risk in the state.</p>	<p>The program will educate all people in CT</p>

<p>Funding is for the health access programs, comprehensive reproductive health and family planning, and a grant award for Fair Haven Health Center.</p>	<p>Comprehensive reproductive and family health services are provided to 14 areas with a high concentration of low-income women of reproductive age and with a high rate of teen pregnancy in: Bridgeport, Danbury, Enfield, New Haven, Hartford North, Manchester, Meriden, New London, Norwich, Stamford, Torrington, Waterbury, West Hartford and Willimantic. This program is currently administered by Planned Parenthood of Southern New England, Inc. (PPSNE). The Health Access Program implemented by Project Access New Haven and Staywell Health Care, provides patient navigation services to low-income, uninsured, or underinsured individuals who need specialty medical care. This is done through a coordinated system of physicians, hospitals and community organizations working together to provide donated specialty health care and ancillary services through a network of volunteer physicians and hospitals.</p>
<p>Funding is provided to the Connecticut Alliance to End Sexual Violence to fund nine rape crisis centers throughout Connecticut. The rape crisis centers provide services that are free, confidential, available 24-hours a day, to sexual assault victims and their families. Services include counseling, advocacy and support, police, court, and medical accompaniment, emergency transportation, 24 hour-hotline services in English and Spanish.</p>	<p>Available statewide to sexual assault victims and their families</p>
<p>Connecticut's Tuberculosis Control Law (C.G.S. 19a-265) was passed to help control the spread of tuberculosis (TB) and to prevent the development of multidrug-resistant (MDR) TB in the population. The State of Connecticut X-Ray Screening and Tuberculosis Care fund is used by the Department of Public Health TB Control Program to reimburse healthcare providers including hospitals, laboratories, and local health departments for the care and treatment of persons with TB in Connecticut. Funds are also used to distribute TB medications to under and uninsured persons.</p>	<p>Under C.G.S 19a-265, the State of Connecticut is the payor of last resort for persons evaluated or treated for TB disease or infection. All persons in Connecticut with TB can be serviced.</p>

<p>Eligible Health Departments &amp; Districts shall use per capita to directly provide overall public health programs and services to their community as defined in C.G.S. Section 19a-207a.</p>	<p>The program services all constituents that reside in the funded municipality or district via various public health programs.</p>
<p>Currently sexually transmitted infections (STIs) chlamydia, gonorrhea and syphilis remain high in Connecticut (CT). The funding for the Veneral Disease Control Program is utilized for an MOA with UConn Health Speciality Pharmacy to distribute STI medications to STI clinics and clinics that serve persons who are at risk for STIs. Additionally, funds are utilized to support a lab courier service to ensure STI specimens are delivered to the State Public Health Laboratory within a timely manner. Funds will also be utilized to support a contract(s) for STI Clinical and Preventitive Services (pending RFI/RFP).</p>	<p>The program will serve CT residents who are at risk for STIs, including younger persons (&lt; age 25), person of color and LGTBTQ+. Women of child bearing age are also a focus to identify syphilis infections and prevent transmission to their fetus (congenital syphilis).</p>
<p>Funding for medical, mental health and dental SBHC located in cities and towns with socio-economic needs.</p>	<p>All students located within the schools where SBHC are located.</p>

## What metrics are being used to gauge success??

CGS 19a-124 requires that programs include an annual evaluation component with specific metrics that measure how the program is functioning and its public health impact. These key metrics include: 1) Number of syringes distributed and collected, 2) Program participation rates, 3) Number of participants referred to treatment services, and 4) Incidence of HIV from injection drug use

Metrics used for RPCM and Reproductive Health contracts are number of pre-teens, teens and young women served, enrolled in prenatal care, number of positive birth outcomes of pregnant clients and number of postpartum visits made and completed by doula services, in-home and clinically. In FFY 25, 377 pregnant or parenting women and teens were served.

The CYSHCN Program follows the national performance measures under the Maternal and Child Health Block grant. CYSHCN contractors are required to provide triannual reports regarding CYSHCN and families served. They also provide an annual Results Based Accountability (RBA) Methodology Report Card, which identifies (3) outcomes-based measures.

Success metrics for AIDS Services generally align with federal Ryan White Program performance measures and Statewide Integrated HIV Prevention and Care Goals and Objectives:

**Health Outcomes** 1) Viral Suppression Rates, 2) Retention in Care, 3) Linkage to Care. **Services Utilization** 1) Number of people served, 2) Service coverage by priority populations (health disparities), and **Prevention Indicators** 1) HIV Testing Rates and Identification of new cases, and 2) PrEP uptake for people at higher risk.

In FY 25, 5,565 high risk women were provided breast and cervical services, including 4,296 clinical breast exams, 3,151 mammograms, and 3,010 Pap tests with 2,714 HPV co-testing through program funding.

Success is measured by the number of vaccine doses purchased and distributed statewide and by overall vaccine coverage rates for vaccine preventable diseases. The program tracks average monthly distribution to project annual dose requirements and maintains a three month minimum inventory to ensure continuity of supply. The program also monitors and assesses provider vaccine ordering patterns and demand and adjusts purchasing and distribution accordingly to prevent shortages or overstocking. Additional indicators of success include the program's ability to maintain universal vaccine program status and minimize disruptions in vaccine access.

Program gauges success by number of completed screening and residents reached with a long term goal of increasing Lung Cancer Screening Rates.

Success is being measure by monthly programmatic reports from CBO's receiving funding, highlighting programmatic participation and outcomes. Firearm safe distribution is also being tracked and surveys administered.

Success will be measured with social media metrics and visits to the DPH referrals page. Because no direct services are provided, we cannot measure by screenings

In FY25, the Family Planning program provided family planning/reproductive health services to 40,792 individuals. Metrics also include the number of eligible clients that have access to and receive reproductive health care services, regardless of ability to pay; and the number of clients having a preventive reproductive health exam receive breast and cervical cancer screening, prevalent bacterial STD screening and AIDS education/counseling. The Health Access Program metrics include number of clients served, number of intake screenings and assessments completed, and number of clients that receive Patient Navigation services that are low-income uninsured adults age 18 and up who live in the Greater New Haven and Waterbury Area and who have an urgent need for specialty care.

In FY 25, The Alliance to End Sexual Violence served 4,847 individuals for crisis intervention services across its nine (9) member centers.

Annual reports provided to DPH include: 1) Number of TB and MDR-TB inpatients and outpatients patients serviced; 2) Types and numbers of providers; 3) Amounts paid for such TB-related services.

All Per Capita recipients submit a budget and justification to the Office of Local Health Administration who reviews it for allowable costs and services. At the end of the year all recipients submit a signed fiscal report demonstrating they properly utilized their funds. New allocations will not be granted until a fiscal report from the prior fiscal year is received.

Success will be measured by the number of patients screened and patients successfully treated for positive STIs. Decreases in the number of CT residents reported with chlamydia, gonorrhea and syphilis and a decrease in the number of congenital syphilis cases will also be successes.

Program success for the School Based Health Center (SBHC) is assessed using a combination of quantitative service data and qualitative feedback to capture both service delivery and its impact on student well-being. Key performance metrics include service utilization indicators such as the number of students served, visit volume, types of services provided (e.g., medical, behavioral health, preventive care), and demographic reach. These data help assess access to care and equity in service delivery. Health and educational impact indicators are also monitored, including behavioral health utilization, chronic condition management, and delivery of preventive services (e.g., immunizations, screenings). These measures are associated with school functioning—such as absenteeism and student engagement—to better understand broader outcomes.

## How is the program evaluated??

Evaluation happens at two levels: 1) Local Program Evaluation- Funded Programs collect data and report quarterly and submit an annual report to DPH. 2) State Level Evaluation Establishes Evaluation Requirements- Aggregates information across funded programs, and uses the submitted reports to assess overall effectiveness and compliance with local and federal statutory goals and objectives.

RPCM evaluation focuses on number of clients enrolled, completed screening for social determinants of health (SDoH), prenatal care, risk factors and case management services provided to refer to specialists and providers for any positive screens. The RP Comprehensive Pre-teen and Adolescent Health Services measures number of pre-teen and adolescent clients educated and engaged in pregnancy prevention activities, measured longitudinally across time in middle and high school periods; as well as data collected on enrolled pregnant pre-teens, adolescents and young women, screens completed, enrollment in prenatal care, doula services, birthing support and postpartum visits completed.

The CYSHCN Program looks at a variety of indicators such as the number of CYSHCN served, the number of referrals made to medical providers, state agencies, and community-based providers, and links families to insurance coverage. Surveys are also utilized to evaluate family satisfaction of services provided by contractors. Focus groups are conducted annually to gauge family feedback.

Federal and state reporting, Statewide Integrated HIV Prevention and Care Plan Tracking & Monitoring, Surveillance Data, and Quality Improvement efforts.

Using an external evaluator, program evaluation focus on data collected on number of women reached, screened and diagnosed, including demographics. Outreach activities and education are also measured as well as impact on special populations e.g. low income, justice involved etc. Data collection on impact of evidence based interventions used to increase breast and cervical cancer screening in CT populations.

The program is evaluated through proactive and ongoing oversight, with monthly review of vaccine distribution, uptake trends, provider ordering patterns, and supply levels to ensure uninterrupted access. Monthly monitoring of dose distribution and current inventory levels is conducted using a structured forecasting methodology to project annual needs and determine order volumes for the upcoming fiscal year. This data driven approach supports accurate forecasting, cost effective purchasing, compliance with CDC requirements, and sustained vaccine availability.

Program evaluation focus on data collected on number of residents reached, completed screening and navigation, social determinants of health (SDoH), lung cancer screening rates per health system, and primary care providers educated.

Program evaluation is being conducted in partnership with the Yale School of Public Health.

Program evaluation will focus on online engagement.

Evaluation focuses on data collected on the number of patients served, collected on number of clients enrolled, completed screening for social determinants of health (SDoH), and to referrals to specialists and providers for any positive screens.

We work with an external evaluator from the Consultation Center at Yale Inc, to help us assess needs and address gaps. Program evaluation focuses on data collected on number of individuals served, services offered. Outreach activities and education activities are also evaluated. Data collection on impact of evidence based interventions used to decrease the occurrence of SV across CT populations.

This fund and its activities are monitored and evaluated through: 1) Weekly and monthly communications with DPH Fiscal Office; 2) Weekly check-ins with TB Program Supervising Nurse and Epidemiologists-Case Managers; and 3) Weekly financial reports generated from DPH Accounts Payable (via CORE-CT/STARS).

Program success is evaluated through annual financial reports.

Evaluation is conducted through regular monitoring of UConn Health Specialty Pharmacy monthly medication dispensing reports and quarterly review of financial statements. There is monthly review of courier service related to specimens delivered to the State Lab. The STD Program Surveillance Unit provides surveillance data of positive STIs reported to DPH.

Program quality and effectiveness are evaluated through regularly administered surveys of participating sites and contractors. These surveys assess operational performance, implementation fidelity, and perceive effectiveness of services. Qualitative data are also collected to provide contextual insight into program performance, including emerging trends in student needs, barriers to care, operational challenges, and notable successes. This information helps identify service gaps, inform program improvements, and guide resource allocation. Findings from these quantitative and qualitative sources are used for ongoing monitoring and continuous quality improvement to refine service delivery, address emerging needs, and ensure the SBHC program remains responsive to the populations it serves.